DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/31/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445228	A. BUILDING _____ B. WING _____	07/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF GREENEVILLE	725 CRUM STREET GREENEVILLE, TN 37743

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual recertification survey and complaint investigation #28742 and #30028 were completed on July 23-27, 2012, at Life Care Center of Greeneville. No deficiencies were cited related to complaint investigation #28742 and #30028 under 42 CFR PART 482.13, Requirements for Long Term Care Facilities.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156	What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice: a) Social Services, Admissions & Business Office personnel were in-serviced on procedure of issuing Liability and Appeal Notices prior to discharge on 8/2/12 by the Executive Director. How you will identify other residents having the potential to be affected by the same defiant practice and what corrective action will be taken: a) All residents currently receiving Medicare services upon discharge have the potential to be affected. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: a) Social Services, Admissions & Business Office personnel were in-serviced on appropriate procedure and expectations of issuing Liability and Appeal Notices prior to discharge by the Executive Director on 8/2/12. b) Liability and Appeal Notices will be issued prior to discharge. c) Social Services Director and/or Business Office Manager Assistant will conduct financial record audits weekly for 4 weeks and monthly for 2 months to monitor compliance of Liability and Appeal Notice completion prior to discharge.	9/10/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 8/10/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 156	How the corrective action(s) will be monitored to ensure the deficient practice will not recur: a) Beginning 8/2/12 Liability and Appeal Notices will be issued prior to discharge. Social Services Director and/or Business Office Manager Assistant will begin conducting financial record audits weekly for 4 weeks and monthly for 2 months to monitor completion of Liability and Appeal Notices upon discharge. b) The Social Services Director and/or Business Office Manager Assistant will report results from the audits to the facility's Executive Director. c) The Performance Improvement Committee will review the results and; if deemed necessary by the committee, additional education may be provided. The process may be evaluated/ revised and/or the audits reviewed for 3 months or until 100% compliance is achieved. d) Performance Improvement Committee members are the Executive Director, the Medical Director, the Director of Nursing, the Assistant Director of Nursing, the MDS Coordinator, the PPS Nurse, the Rehab Service Manager, the Social Service Director, the Dietary Manager, the Pharmacist, the Maintenance Director, the Business Office Manager, the Housekeeping Supervisor, the Staff Development Coordinator and the Wound Care Nurse. .	

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F 156	Continued From page 2 The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and review of the resident's financial record the facility failed to provide Liability and Appeal notices to two dicharged residents (#61 & #160) of thirty one residents reviewed in stage 2 of the quality indicator survey. The findings included: Interview and financial record review with the Admission Coordinator in the facility conference	F 156		

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F 156	Continued From page 3 room on July 26, 2012, at 9:03 a.m., confirmed the facility failed to provide resident #61 and #160 with a Liability and Appeal notice.	F 156		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to ensure one resident (#203) was free from physical restraints of thirty-one residents reviewed in Stage 2 of the Quality Indicator Survey. The findings included: Resident #203 was admitted to the facility on May 25, 2012, with diagnoses including Alzheimer's Disease, Dementia, and Right Heel Wound. Medical record review of the admission Minimum Data Set (MDS) assessment dated June 1, 2012, revealed the resident was severely cognitively impaired and totally dependent on staff for all ADLs (Activities of Daily Living). Continued MDS review revealed the resident did not require physical restraints. Medical record review of the resident's care plan dated May 25, 2012, revealed the resident had been assessed and care planned for a lap buddy (a foam device over the lap and notched at the	F 221	What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice: a) All licensed personnel were in-serviced on correct assessment of self releasing and positional devices on 8/6/12 through 8/09/12 by the Staff Development Coordinator. b) Resident #203 re-evaluated and after reassessing current device the restraint committee determined resident #203 positional needs was better met in a broda chai r on 8/3/12. Self releasing device discontinued and care plan updated on 8/3/12. How you will identify other residents having the potential to be affected by the same defiant practice and what corrective action will be taken: a) All residents with self releasing and positional devices have the potential to be affected. b) All residents with self releasing and positional devices were assessed for proper intervention on 8/7/12. No other residents were found to be affected. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: a) All licensed facility personnel were in-serviced by the Staff Development Coordinator on correct assessment of self releasing and positional devices on 8/6/12 through 8/9/12.	9/10/12

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F 221	Continued From page 4 arm of a wheelchair to prevent rising from a chair unassisted) on May 27, 2012. Continued record review revealed on May 28, 2012, the lap buddy was reduced to a self release alarming seat belt type restraint. Observation of resident #203, on July 24, 2012, at 9:10 a.m., and on July 25, 2012, at 9:55 a.m., revealed the resident in a geri-chair near the A (Aspen) hall nursing station. The resident was confused and mumbling to self, and had a self release alarming seat belt secured around the waist. The resident was unable to release the seat belt when requested, at the time of both observations. Interview with the Clinical Manager for the A hall on July 25, 2012, at 10:05 a.m., in the A hall nursing station, confirmed the resident was unable to follow the command to self release the seat belt. Continued interview confirmed the device could not be released by the resident and was a restraint.	F 221	b) Restraint Committee will monitor correct assessment of self releasing and positional devices for 4 weeks and monthly thereafter. c) Restraint Committee members are the Executive Director, the Director of Nursing, the Rehab Service Manager, the Assistant Director of Nursing, the Activities Director and the Social Services Director. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; a) Restraint Committee will monitor correct assessment of self releasing and positional devices for 4 weeks and monthly thereafter. b) Restraint Committee members are the Executive Director, the Director of Nursing, the Rehab Service Manager, the Assistant Director of Nursing, the Activities Director, and the Social Services Director. c) The Performance Improvement Committee will review the results and; if deemed necessary by the committee, additional education may be provided. The process may be evaluated/ revised and/or the audits reviewed for 3 months or until 100% compliance is achieved.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine;			

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F 272	Continued From page 5 Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to accurately assess one resident for a restraint (#203), and failed to perform a quarterly bowel and bladder assessment for one resident (#93), of thirty-one residents reviewed in Stage 2 of the Quality Indicator Survey. The findings included:	F272	d) Performance Improvement Committee members are the Executive Director, the Medical Director, the Director of Nursing, the Assistant Director of Nursing, the MDS Coordinator, the PPS Nurse, the Rehab Service Manager, the Social Service Director, the Dietary Manager, the Pharmacist, the Maintenance Director, the Business Office Manager, the Housekeeping Supervisor, the Staff Development Coordinator and the Wound Care Nurse. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice: a) MDS personnel were in-serviced 8/2/12 on proper coding and completion of the MDS and quarterly assessments by the Director of Nursing. b) Resident #93 bowel & bladder assessment not completed in June 2012. Resident # 93 Bowel & bladder assessment completed 8/2/12 by the MDS Coordinator. c) Resident # 203 not assessed for restraint. Resident #203 re-evaluated and after reassessing current device the restraint committee determined resident #203 positional needs was better met in a broda chair 8/3/12. Self releasing device discontinued and care plan updated 8/3/12.	9/10/12

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F 272	Continued From page 6 Resident #203 was admitted to the facility on May 25, 2012, with diagnoses including Alzheimer's Disease, Dementia, and Right Heel Wound. Medical record review of the admission Minimum Data Set (MDS) assessment dated June 1, 2012, revealed the resident was severely cognitively impaired and totally dependent on staff for all ADLs (Activities of Daily Living). Continued MDS review revealed the resident did not require physical restraints. Medical record review of the resident's care plan dated May 25, 2012, revealed the resident was assessed and care planned for a lap buddy (a foam device placed over the lap and notched to fit the arms of a wheelchair to prevent rising from a chair unassisted). Continued medical record review revealed on May 26, 2012, the lap buddy was reduced to a self release alarming seat belt type restraint. Medical record review revealed the MDS and the care plan had not been updated to reflect the new restraining device. Observation of resident #203, on July 24, 2012, at 9:10 a.m., and on July 25, 2012, at 9:55 a.m., revealed the resident in a geri-chair near the A (Aspen) hall nursing station. The resident was confused and mumbling to self and had a self release alarming seat belt secured around the waist. The resident was unable to self release the seat belt when requested at the time of both observations. Interview with the Clinical Manager for the A hall on July 25, 2012, at 10:05 a.m., in the A hall nursing station confirmed the resident was unable to follow the command to self release the seat	F 272	How you will identify other residents having the potential to be affected by the same defiant practice and what corrective action will be taken: a) All facility residents have the potential to be affected. b) 100% review of bowel and bladder assessments completed and no areas of concern found 8/2/12. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: a) All MDS personnel were in-serviced on 8/2/12 of proper coding and completion of the MDS and quarterly assessments by the Director of Nursing. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: a) Director of Nursing and/or Assistant Director of Nursing will do 100% weekly audits on all MDS assessments and quarterly assessments for the week for completion of required areas. Audits will be completed weekly for 4 weeks and monthly for 2 months to monitor compliance of MDS assessments and quarterly assessments. b) Results will be turned in the facility's Executive Director and/or Director of Nursing. The Executive Director and /or Director of Nursing will report findings monthly to the Performance Improvement Committee.	

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F 272	Continued From page 7 belt. Continued interview confirmed the device was a restraint and the MDS and the care plan had not been updated to include restraint assessments and interventions. Resident #93 was admitted to the facility September 5, 2011, with diagnoses including Altered Mental Status, Atrial Fibrillation, Dementia, and Hypertension. Medical record review of the Minimum Data Set (MDS) assessment dated May 13, 2012, revealed the resident was severely cognitively impaired, required assistance of one to two staff with activities of daily living, was frequently incontinent of bladder, and occasionally incontinent of bowel. Medical record review of the facility Assessment for Bowel and Bladder Training record revealed the resident had been assessed September 5, 2011, December 5, 2011, and March 5, 2012. Interview with LPN #1, on July 26, 2012, at 11:00 a.m., in the MDS office, confirmed the facility had not completed a quarterly bowel and bladder assessment since March 2012.	F 272	c) The Performance Improvement Committee will review the results and; if deemed necessary by the committee, additional education may be provided. The process may be evaluated/ revised and/or the audits reviewed for 3 months or until 100% compliance is achieved. d) Performance Improvement Committee members are the Executive Director, the Medical Director, the Director of Nursing, the Assistant Director of Nursing, the MDS Coordinator, the PPS Nurse, the Rehab Service Manager, the Social Service Director, the Dietary Manager, the Pharmacist, the Maintenance Director, the Business Office Manager, the Housekeeping Supervisor, the Staff Development Coordinator and the Wound Care Nurse. .	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice: a) All utensils were sanitized again for at least one minute. b) All dietary personnel were immediately in-serviced by the Dietary Manager on Life Care policy of Proper Three Compartment Sink Wash Sequence and Procedure and ensuring immerse washed and rinsed utensils are to be sanitized for at least one minute.	9/10/12

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F 371	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review and interview, the facility failed to properly clean and sanitize by use of the three compartment sink. The findings included: Observation in the kitchen on July 23, 2012, at 9:38 a.m., revealed Dietary Aide #1 cleaning three 18/8 pans and the large beater for the mixer, in the three compartment sink. Continued observation at this time revealed the Dietary Aide washed the pans and the beater, rinsed the pans and the beater. Observation revealed the Dietary Aide then placed the items in the sanitizer part of the sink for 10 seconds and placed the items out to dry. Review of facility policy, Proper Three Compartment Sink Wash Sequence and Procedure, revealed "...Immerse washed and rinsed utensils in sanitizer for one minute..." Interview and review of the posted sanitizer instructions with the Dietary Manager on July 23, 2012, at 2:00 p.m., confirmed items cleaned in the three compartment sink are to be placed in the sanitizer for at least one minute prior to taking out of the sanitizer.	F 371	How you will identify other residents having the potential to be affected by the same defiant practice and what corrective action will be taken: a) All facility residents have the potential to be affected. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: a) All dietary personnel were in-serviced on Life Care policy of Proper Three Compartment Sink Wash Sequence and Procedure on 7/23/12. b) Dietary manager will monitor and record weekly for Proper Three Compartment Sink Wash Sequence and Procedure for 4 weeks and monthly for 2 months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: a) Beginning 7/24/12, Dietary Manager will monitor and record weekly for 4 weeks and monthly for 2 months for Proper Three Compartment Sink Wash Sequence and Procedure. b) Results will be turned in the facility's Executive Director. The Executive Director will report findings monthly to the Performance Improvement Committee.	
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.			

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F 502	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to follow physician's orders for laboratory services for one (#95) of thirty-one residents reviewed in Stage 2 of the Quality Indicator Survey. The findings included: Resident #95 was admitted to the facility on May 3, 2012, with diagnoses including Chronic Kidney Disease, Diabetes, Post Hemorrhage Anemia, and Ulcerative Colitis with Colectomy. Medical record review revealed a Physician's admission order dated May 3, 2012, to obtain "weekly hemoglobin (HGB) and hemocrit (HCT)every Monday...Start May 7, 2012." Medical record review of the lab reports revealed the lab was completed on May 9, 2012, (two days later). Medical record review of teh lab reports revealed HGB 7.5 (normal 14.0-18.0) with HCT 23.0 (42.0 - 52.0). continued medical record review revealed the Physician was notified on May 10, 2012, and ordered the resident to be sent to the hospital for a blood transfusion. Interview with the Director of Nursing (DON) in the Administrator's office on July 26, 2012, at 10:00 a.m., confirmed the Physician's order was not followed and the lab was obtained two days late.	F502	c) The Performance Improvement Committee will review the results and; if deemed necessary by the committee, additional education may be provided. The process may be evaluated/ revised and/or the audits reviewed for 3 months or until 100% compliance is achieved. d) Performance Improvement Committee members are the Executive Director, the Medical Director, the Director of Nursing, the Assistant Director of Nursing, the MDS Coordinator, the PPS Nurse, the Rehab Service Manager, the Social Service Director, the Dietary Manager, the Pharmacist, the Maintenance Director, the Business Office Manager, the Housekeeping Supervisor, the Staff Development Coordinator and the Wound Care Nurse. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice: a) Facility personnel responsible for lab requisitions were in-serviced on 7/26/12 by Assistant Director of Nursing regarding timely completion of physicians orders. How you will identify other residents having the potential to be affected by the same defiant practice and what corrective action will be taken: a) All facility residents who have lab work have the potential to be affected. b) 100% review of residents who receive lab work completed and no areas of concern found 8/2/12.	9/10/12

PRINTED: 07/31/2012
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445228	A. BUILDING _____ B. WING _____	07/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF GREENEVILLE	725 CRUM STREET GREENEVILLE, TN 37743

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